PUBLIC HEALTH AGENCY of CANADA

Discussion Paper

Canada-United States Border Health Initiatives: Opportunities and Challenges

A Provincial/Territorial Perspective

Version 2
April 2008

Discussion Paper

Canada-United States Border Health Initiatives: Opportunities and Challenges

A Provincial/Territorial Perspective

Version 2

Prepared for: **Centre for Emergency Preparedness and Response**
Public Health Agency of Canada

Prepared by: **Wayne Dauphinee**
Disaster Health Services Consultant

Date: **April 2008**

Acknowledgement

In preparing this paper I owe a debt of gratitude to my colleagues in the Eastern and Great Lakes Border Health Initiatives, the Mid-America Alliance and the Pacific North West Public Health Collaboration for their commitment in advancing the need for cross border collaboration and protocols to ensure seamless delivery of health services along the Canada – United Stated border.

Forward

This document, which is both a compendium and a review of current cross border initiatives, is intended to provide both “food for thought” regarding the myriad of cross border issues related to mutual assistance and to suggest some possible approaches for addressing those issues. Specifically, the paper attempts to identify and discuss the broad range issues, impacts and challenges confronting provinces and territories in negotiating, implementing and sustaining cross-border health collaboration and mutual assistance agreements with United States (US) jurisdictions.

While some parties may wish to share resources only upon a declaration of emergency others may be prepared to share resource as a method of providing surge capacity in response to smaller, non-declared emergencies. It would therefore behove planners to recognize that resource sharing may be an effective means of providing routine public health functions in border jurisdictions. In this regard, it is suggested that the approaches presented not be considered in isolation but rather be reviewed in the context of a specific region/jurisdiction’s mutual assistance requirements.

Ideally, from an emergency planners perspective, this paper will support the development of an integrated pan-Canadian border health strategy that recognizes the need to develop regional mutual aid mechanisms to prepare for and respond to non-(governor/premier) declared public health emergencies and to create a *Canada-United States Border Health Alliance* to coordinate this effort.

Executive Summary

Notwithstanding that SARS and the threat of an influenza pandemic have largely provided the impetus for current "high visibility" cross border public health initiatives on going day to day collaboration has and continues to take place at the local/county level. For example, the cross border movement of patients for reasons of both capacity and capability remains a challenge particularly with the implementation of new border security identification requirements. While border and information security considerations must be respected they must not be allowed to compromise the health and safety of residents on either side of the border.

Health authorities along the Canada-United States (US) border face challenges in partnering with neighbouring jurisdictions that may not share the same priorities, laws, resources or, in the case of Quebec and New York, language. Differences in epidemiological case definitions, communication systems and personnel licensure are among the issues that must be resolved in order for provinces/territories and states to enhance cross-border public health preparedness.

The issues confronting cross border planners are virtually identical in all regions, particularly with regard to human resources and information sharing. The human resources issues are licensing/credentialing, liability indemnification and compensation/ benefits while the information sharing concerns focus on security of personal information and the potential for US Patriot Act compromise. While emergency legislation can overcome licensure requirements it is generally accepted that jurisdictions should have an established mechanism for granting emergency/ temporary licenses. Likewise hospitals and other treatment facilities should have similar mechanism to grant emergency temporary privileges.

A key priority of provinces/territories and states along the Canada-US borders is the development of a mechanism to address the public health preparedness needs of the entire border region. The establishment of a *Canada-United States Border Health Commission*, or similar organizational structure, would allow provinces/ territories and states to more effectively collaborate to address common challenges, share resources, and identify strengths and weaknesses.

Provincial/territory health leadership also see a need for comprehensive federal coordination of the various federal programs related to cross-border public health preparedness. Greater coordination at the federal level would achieve consistency across the border region and eliminate time and resource-wasting duplication of effort. Federal coordination is also needed to address areas of international law that are beyond the authority of the cross border jurisdictions

Consistent federal support for all-hazards cross-border preparedness planning is also needed. There must be recognition of the costs of ensuring cross-border public health preparedness as well as providing greater flexibility in understanding justifications for incremental spending priorities.

The challenge confronting provinces/territories and states in coordinating cross border activities with First and Tribal Nations adds a dimension that extends well beyond public health preparedness. A meeting between health authorities responsible for cross border aboriginal health care may be an effective way to address public health preparedness while recognizing issues related to First and Tribal Nations sovereignty and cultural differences,

Lastly, if there is a true willingness to collaborate/cooperate/assist one another during health emergencies, enabling protocols must be established and routinely implemented. Canada and the US need to consider implementing, in a North American context, mutual assistance and standardization/ interoperability protocols for health. These protocols would mirror those established for the North Atlantic Treaty Organization (NATO) Alliance

Table of Contents

SECTION 6 – PUBLIC HEALTH AGREEMENTS AND ARRANGEMENNTS

SECTION 7 – FIRST AND TRIBAL NATIONS CONSIDERATIONS

SECTION 8 – NEXT STEPS

SECTION 9 – CONCLUSIONS AND RECOMMENDATIONS

SECTION 1 – INTRODUCTION

By mutual confidence and mutual aid - great deeds are done, and great discoveries made

Homer

General

Health infrastructure requires sufficient capacity to address extraordinary demands (surge) related to emergencies affecting the public health and/or health care delivery systems. Mutual assistance arrangements are recognized as a key platform for the creation of surge capacity.

Before turning to an analysis of cross border initiatives, it is important to understand the border of reference. The Canadian-US border is the longest non-militarized border in the world, with more than 4,900 kilometres (3,100 miles) on land and nearly 3,900 kilometres (2,400 miles) by water. About 90 percent of Canada's population lives within 160 kilometres (100 miles) of the border and crossings are frequent with more than 200 million two-way border crossings occur each year[1]. The openness of the border allows the potential for easy spread of diseases between the two countries and there could also be serious consequences for state and provincial emergency response should the border be closed. In Michigan alone, it is estimated that 4,000 health care workers cross the border in the Detroit area each day to work. The capacity of Michigan hospitals to respond to a mass event would be diminished if these Canadian workers were unable or unwilling to report to work.

To date the focus of much of the cross border work that has been undertaken has been around mutual assistance in an emergency/disaster response context. While the validity of that approach isn't in question, a more comprehensive approach will be required to effectively manage cross border public health issues – viruses and bacteria don't clear customs and immigration. In this regard, cross border public health mutual assistance must be addressed in a comprehensive and integrated manner.

Mutual assistance in a public health context is a collaborative process which embodies both the traditional sharing of supplies, equipment and personnel and the equally essential sharing of epidemiological and other health information across political boundaries. In Canada, the first steps in establishing effective public health collaboration were taken when the pan-Canadian Public Health Network was established in 2005. Among the first priorities the Network addressed was the need for both a pan-Canadian mutual assistance

[1] Building a Border for the 21st Century: " *The Canada-U.S. Partnership* (CUSP) *Forum Report*" Ottawa, October 1999

arrangement and an information sharing agreement. While yet to be formally ratified by the parties, the Federal/Provincial/Territorial (F/P/T) Memorandum of Understanding (MOU) on the Provision of Mutual Aid in Relation to Health Resources During an Emergency Affecting the Health of the Public is a significant legal tool for sharing resources across F/P/T boundaries, including, personnel, equipment, and supplies. In addition to the traditional types of mutual aid required in a disaster (personnel, equipment and supplies), sharing epidemiological or laboratory information and specialized personnel across inter-provincial/territorial and international borders may be essential to detecting and controlling future infectious disease outbreaks, whether occurring naturally (SARS or intentionally (Bioterrorism). In this regard, bordering jurisdictions would do well to have agreements in place to ensure collaboration/mutual assistance in all forms to facilitate effective responses to disasters, such as hurricanes and floods, and to detect and control potential infectious disease outbreaks before they become disasters. Recent public health emergencies have heightened the recognition of potential and actual obstacles to effective mutual assistance and have exposed legal "gaps," in the mutual assistance agreement process that must be filled.

Background

It is commonly stated that disease transmission knows no borders. In today's global economy, an infectious disease can be carried anywhere in the world in a matter of hours. Unlike other extreme events, infectious disease outbreaks and bioterrorist attacks tend to be invisible and their effects are likely to spread among the population before they are identified. The first detection of disease may occur when an individual presents with symptoms two to ten days after infection. It is essential to the safety and security of the United States and Canada that public health entities have the capability to rapidly detect and track outbreaks in order to stop them and reduce their impact.

The United States and Mexico have been involved in a Border Health Commission for a number of years and have faced many of the challenges in carrying out effective cross-border public health preparedness efforts that are confronting their counterparts on the Canada-United Sates border. That said, the United States-Mexico border region has some unique circumstances, including a language barrier and a high volume of illegal border crossings, which complicate the issue well beyond the scope of what is currently being considered by Canada- US border jurisdictions.

Public health entities need to be able to work together and share information with neighbouring jurisdictions as a means to identify trends in the spread of disease, raise awareness of potential threats and assist each other in responding. Within both the US and Canada, a number of tools and resources have been developed to improve communications capacity, establish common protocols and standards, and ensure a basic level of preparedness in all areas of the country. For

example, in the United States the Laboratory Response Network (LRN) is an integrated network of laboratories that has the capacity to respond to chemical and biological terrorism, infectious diseases and other public health emergencies anywhere in the country. Similarly, resources such as the Health Alert Network (HAN) and the Epidemic Information Exchange (Epi-X) allow for distribution of important information to key public health and other response personnel. In Canada, programs like the Canadian Integrated Public Health Surveillance (CIPHS) bring together a strategic alliance of public health and information technology professionals working collaboratively to build an integrated suite of computer and database tools specifically for use by Canadian public health professionals. Another collaborative tool is the Canada Communicable Disease Report (CCDR), a weekly digest of national and international information about communicable disease incidents and issues. CCDR weekly include: Infectious disease news; FluWatch Summaries; Preliminary Outbreak Reports, including linkages to information in existing provincial/ territorial news bulletins; and other announcements. Building on existing information exchange/sharing tools provides a "grass-roots" approach in avoiding jurisdictional sensitivities.

Federal Government Role

There is no question that international agreements and arrangements fall within the authority of the respective federal governments of Canada and the United States. That said, one can not ignore that public health organizations along the border have a long tradition of working together informally on issues impacting public health of their respective jurisdictions.

The increased attention to public health preparedness in recent years has raised awareness of areas in need of greater discussion and collaboration and, perhaps, more formal procedures. As provinces and states continue to work together at the local/regional levels there is a need for a greater understanding of how the Canadian government, and particularly its health system, works.

Canada

While there are many significant differences in the structures of the health systems in the US and Canada, there are also some parallels. Like the Department of Health and Human Services (HHS) in the US, Health Canada has a national focus. Similarly, the Public Health Agency of Canada, which was established following the SARS outbreak, serves functions comparable to the CDC. The National Health Emergency Management Framework is an agreement among all of the Canadian provinces about how to respond to major incidents. This strategic plan is similar to the National Response Plan (NRP) in the US and is intended to provide consistency across the country. Canada is also developing a National Health Emergency Management System. Although this system is

focused on health, it has similarities to the US National Incident Management System (NIMS).

These federal agencies and plans provide an overall structure for the Canadian health system, but, as is similarly the case in the US, there is considerable variation province to province. There is continual cooperation at the federal level between the two countries that has resulted in a number of formal agreements, such as the inclusion of two Canadian laboratories, the National Microbiological Laboratory in Winnipeg and the Defence Research and Development Canada Laboratory in Suffield, in the LRN. However, much of the interaction between the US and Canada happens at the state to province, health department to health department and individual to individual levels. State and provincial health departments would benefit from clearer guidance from their respective federal governments about their authority to do business with their partners.

United States

Recognizing that states with international borders face challenges in identifying and controlling infectious disease outbreaks, the Centers for Disease Control and Prevention (CDC) has provided funding for surveillance activities to states along the borders with Canada and Mexico. Under the Early Warning for Infectious Disease Surveillance (EWIDS) program funding has totalled in excess $20 million. Each of the 20 US border states receives base funding of $15,000 plus an allocation based on the number of legal border crossings in that state. Additionally, $5.4 million has been provided to the US-Mexico Border Health Commission to fund activities in the six Mexican states bordering the US.

EWIDS funds are used to increase public health surveillance and detection capacity, enhance epidemiological investigation and response capacity, upgrade laboratory capacity, improve surveillance-related communications and technology, and develop surveillance-related education and training in the border states. Activities funded by EWIDS are intended to improve overall surveillance capabilities, enable sharing of data and assure that public health personnel are appropriately trained to carry out surveillance activities. Beginning with the 2005 CDC Cooperative Agreement, states receiving EWIDS funds were allowed to leverage their resources by engaging in regional planning efforts.

Another federal resource is the CDC's Division of Global Migration and Quarantine (DGMQ). One of the primary missions of DGMQ is to prevent the spread of infectious diseases into the US. In addition to their historic inspection function, public health and medical officers at the quarantine stations prepare for and respond to ill passengers, work with community partners, and provide health and disease information. As part of their efforts to improve isolation capacity, the CDC DGMQ has entered into agreements with hospitals near the quarantine stations to ensure that space is available if necessary.

At the beginning of 2005, there were eleven quarantine stations; seven more have opened or are planned to be open by the end of 2008. This expansion is planned to continue to several additional cities in the coming years. Cities chosen for expansion will have greater than one million airport travelers, more than 100,000 seaport entries or at least five million land border crossings per year.

Many other federal agencies also engage in activities that impact cross-border public health preparedness efforts. For example, US Customs and Border Protection has responsibility for protecting the US borders and may be called upon to halt travel between the US and its neighbours in the event of an emergency. The Indian Health Service provides federal health services and advocacy on behalf of the 1.5 million members of federally-recognized tribes, many of whom live on lands bordering Canada and Mexico. Among other functions, the Department of State coordinates the foreign activities of other agencies, such as HHS.

Each of these and other federal agencies has unique and specific roles. While the scope of these roles often overlaps, there is little coordination among the agencies to craft a common approach to issues related to cross-border public health preparedness or to assure that their activities complement rather than conflict with each other. Additionally, public health is often an afterthought at best for many of the federal agencies involved in international collaborations. Often, states do not know which federal agency to turn to for assistance, particularly among those agencies with which public health has traditionally had limited involvement.

SECTION 2 – HIGH LEVEL AGREEMENTS, ARRANGEMENTS AND ALLIANCES

General

While the intent of this paper is to discuss cross border health from a provincial-territorial perspective it is important that we recognize, and where appropriate consider, existing arrangements, alliances and other authorities that could directly or indirectly influence the dynamic of cross border mutual assistance. This section provides an overview of agreements, arrangements and alliance already in existence.

The genesis of what we embrace today as Canada-US mutual assistance was the collective defence alliances formed following World War II, during what was regarded as the “cold war”. While the focus of mutual assistance has turned from communism to terrorism, the need for a collaborative all-hazard approach to emergency response remains unchanged. It must be recognized that regardless of whether or not the collaboration is for defence or disaster response, success rests on the ability of the parties, often with diverse capabilities and capacities, to work together effectively - interoperability.

While floods, hurricanes/tornados, wild fires and other naturally occurring events are the most likely scenarios to impact Canada-United States border jurisdictions, it is the consequences of a national security threat that poses the greatest challenge in cross border collaboration.

Multi-National Alliances

North Atlantic Treaty Organization (NATO)

As part of its overall responsibilities, and to contribute to the security of member nations, the NATO alliance early on recognized the importance of civil protection (vulnerability reduction) in developing population resilience. In this regard, the alliance created a civil-military authority to capitalize on the military component’s interoperability initiatives to strengthening civil sector resilience. While interoperability within the European Union continues evolved, in North America the proponents of interoperability continue to march to different drummers. Thus our capability to manage what should be a seamless cross border continues to be compromised by our inability to do locally what we have prided ourselves on doing internationally for fifty years.

In the context of NATO’s civil-military collaboration mandate, the alliance could potentially be called on by Canada and the US to coordinate bi-national/cross border measurers through the Senior Civil Emergency Planning Committee

(SCEPC). The SCEPC is assisted in carrying out its role by the Civil Emergencies Planning Directorate which is responsible for:

- The coordination and guidance for the rapid response to civil emergencies;
- The development of arrangements for the use of shared resources in civil emergencies; and
- providing staff support for the SCEPC.

The bottom line for the NATO reference is that standardization and interoperability, as demanded by the military component of the alliance, are recognized as being essential for the provision of mutual assistance between member nations.

Canada-United States-Mexico Security and Prosperity Partnership

The Security and Prosperity Partnership of North America (SPP) was launched in March of 2005 as a trilateral effort to increase security and enhance prosperity among the United States, Canada and Mexico through greater cooperation and information sharing. This trilateral initiative is premised on security and economic prosperity being mutually reinforcing. The SPP recognizes that the parties are bound by a shared belief in freedom, economic opportunity, and strong democratic institutions.

The SPP provides the framework to ensure that North America is a safe and secure place to live and do business. In this regard, it recognizes the need for ambitious security and prosperity programs to keep international borders closed to terrorism yet open to trade. Furthermore, the partnership builds upon, but is separate from, existing trade and economic relationships and energizes other aspects of cooperative relations. In this regard, several of the SPP goals are related to implementing an overall strategy to address intentional and naturally-occurring public health threats in the three nations.

World Health Organization (WHO) International Health Regulations

Since 15 June 2007, the WHO has been implementing the International Health Regulations (IHR) (2005). This legally-binding agreement significantly contributes to international public health security by providing a new framework for the coordination of the management of events that may constitute a public health emergency of international concerns, and will improve the capacity of all countries to detect, assess, notify and respond to public health threats.

Countries that are party to the Regulations have two years to assess their capacity and develop national action plans followed by three years to meet the requirements of the Regulations regarding their national surveillance and

response systems as well as the requirements at designated airports, ports and certain ground crossings[2].

Under the IHR States have committed to collaborate with and assist one another, to the extent possible, in the detection and assessment of, and response to, events; the provision or facilitation of technical cooperation and logistical support, particularly in the development, strengthening and maintenance of the public health capacities; the mobilization of financial resources to facilitate implementation of their obligations; and the formulation of proposed laws and other legal and administrative provisions.

Further, the regulation infers that parties sharing common borders should consider entering into bilateral or multilateral agreements or arrangements concerning prevention or control of international transmission of disease at ground crossings. However, it is recognized that the IHR, and other relevant international agreements, should be interpreted as compatible not adversarial and the provisions of the IHR do not affect rights and obligations derived from other international agreements.

Interestingly, in the context of Canada-US border health initiatives, the IHR is supportive of parties concluding special treaties or arrangements to facilitate the application of the regulations, particularly with regard to: the direct and rapid exchange of public health information between neighbouring jurisdictions; the health measures applied to international traffic in coastal waters within their jurisdiction; the health measures to be applied in contiguous jurisdictions at their common frontier; arrangements for carrying affected persons or human remains; and treatments designed to render goods free of disease-causing agents.

Bi-National

United States Northern Command (USNORTHCOM)

USNORTHCOM was established in 2002 to provide command and control of US homeland defence efforts and to coordinate defence support of civil authorities. The command's area of responsibility includes air, land and sea approaches and encompasses the continental US, Alaska, Canada, Mexico and the surrounding water out to approximately 500 nautical miles. The Commander, USNORTHCOM is responsible for North American security in cooperation with Canada and Mexico.

USNORTHCOM's civil support responsibilities include domestic disaster relief operations during forest fires, hurricanes, floods and earthquakes. Support also includes counter-drug operations and managing the consequences of a terrorist

[2] A two-year extension may be obtained, and, in exceptional circumstances, an additional extension could be granted, not exceeding two years.

event employing chemical, biological and radio-nuclear agents. The command provides assistance to but cannot become directly involved in law enforcement activities.

In providing civil support, USNORTHCOM will normally operate through Joint Task Forces; however, the emergency must exceed the capabilities of local, state and federal agencies before USNORTHCOM becomes involved. In most cases, support will be limited, localized and specific.

Canada Command (Canada COM)

Canada COM was created in 2005 to place greater emphasis on the Canadian Forces' (CF) number one security priority – the safety of the Canadian people. The Commander, Canada COM is responsible for all domestic operations, both routine and contingency and is the designated national operational authority for the defence of Canada and North America. Canada COM is comprised of six regional commands: North, Pacific, West, Central, East, and Atlantic. The Regional commands, or task forces, are responsible for all routine and contingency operations in their respective area of responsibility. The command allows the CF to bring the appropriate military resources from across Canada to bear on a crisis or threat, wherever it occurs, nation-wide. Furthermore, at both the national and regional levels, commanders have the immediate authority to deploy the maritime, land and air assets in their regional areas of responsibility in support of domestic operations.

Canada, U.S. militaries sign cross-border pact

DAVID PUGLIESE
Canwest News Service

Canada and the U.S. have signed an agreement that paves the way for the militaries from either nation to send troops across each other's borders during an emergency, but some are questioning why the Harper government has kept silent on the deal.

Neither the Canadian government nor the Canadian Forces announced the new agreement, which was signed Feb. 14 in Texas.

The U.S. military's Northern Command, however, publicized the agreement with a statement outlining how its top officer, Gen. Gene Renuart, and Canadian Lt.-Gen. Marc Dumais, head of Canada Command, signed the plan, which allows the military from one nation to support the armed forces of the other nation during a civil emergency.

The new agreement has been greeted with suspicion by the left wing in Canada and the right wing in the U.S.

The left-wing Council of Canadians, which is campaigning against what it calls the increasing integration of the U.S. and Canadian militaries, is raising concerns about the deal.

"It's kind of a trend when it comes to issues of Canada-U.S. relations and contentious issues like military integration. We see that this government is reluctant to disclose information to Canadians that is readily available on American and Mexican websites," said Stuart Trew, a researcher with the Council of Canadians.

"Are we going to see [U.S.] troops on our soil for minor potential threats to a pipeline or a road?" he asked.

Trew also noted the U.S. military does not allow its soldiers to operate under foreign command so there are questions about who controls American forces if they are requested for service in Canada.

But Canada Command spokesman Commander David Scanlon said it will be up to civilian authorities in both countries to decide whether military assistance is requested or used.

Canada COM leads Canada's search and rescue operations and also responds to requests from civil authorities for assistance in a wide spectrum of operations such as:

- disaster relief;
- territorial and aerial surveillance and protection;
- coast surveillance; and
- support to federal Counter-Drug Operations.

Canada COM is currently building partnerships with organizations at the provincial/territorial and federal level and on the continental front, Canada COM works closely with US Northern Command. It should be noted that the CF works in support of civil authorities in the delivery of their mandates during crises, or in operations in the national interest that require some of the specialized or unique capabilities of the CF.

It has been noted that both USNORTHCOM and Canada COM are taking an interest in cross border mutual assistance agreements, particularly potential roles for the military, and are now regular participants in regional cross border public health workshops.

SECTION 3 – PUBLIC SAFETY AND EMERGENCY RESPONSE ARRANGEMENTS AND ALLIANCES

Canada-United States Civil Emergency Planning and Management

The 1986 agreement between the United States and Canada on cooperation and comprehensive civil emergency planning and management is generally considered the cornerstone cross border emergency management agreement. The agreement was subsequently reaffirmed in 1998[3]. As such, the agreement establishes the means for bi-lateral cooperation in comprehensive emergency management and facilitates planning for the development of mutual cooperation for comprehensive civil emergency management by provinces, states and municipalities, including the exchange of information relative to prevention, mitigation and assistance.

United States Emergency Management Compact

Since the late 1940s, states have entered into interstate compacts to facilitate the sharing of resources across state lines in response to disasters. The Emergency Management Assistance Compact (EMAC), a Congressionally-ratified, Interstate compact, allows member states to share personnel and equipment during Governor-declared emergencies. States requesting aid are responsible for reimbursement while those that volunteer resources are protected from liability concerns.

The following challenges have been identified on reviewing lessons learned from recent EMAC activations:

- inadequate protocols to communicating resource needs caused deployment delays and confusion among requesting officials and resource providers;
- lack of a comprehensive system to support the tracking of resource requests from initial offers of assistance through mission completion caused delays, duplications of effort, and frustration; and
- existing reimbursement standards are not designed to facilitate timely reimbursement following catastrophic disasters.

Within the US, much progress has been made in formalizing mutual aid agreements between the states. All but two states are signatories of the Emergency Management Assistance Compact (EMAC).

[3] US Department of State Note dated March 17, 1998

Pacific Northwest Emergency Management Arrangement

The Pacific Northwest Emergency Management Arrangement (PNEMA) was signed by Alaska, Idaho, Oregon, Washington, British Columbia and the Yukon Territory and was approved by Congress and the President in 1998. Washington State has been leading an effort to add an annex to PNEMA which specifically addresses issues related to public health that occur in emergencies. In particular, the dissemination of health data and licensing and liability of healthcare personnel are among the topics addressed by the annex.

International Emergency Management Assistance Compact

The International Emergency Management Assistance Memorandum of Understanding, known as IEMAC, was approved by Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, Quebec, New Brunswick, Prince Edward Island, Nova Scotia, and Newfoundland and Labrador in 2000. Approved by the US Senate in 2001, the compact is largely modeled on EMAC and, like EMAC, includes provisions addressing issues such as liability, license reciprocity and worker compensation. As the Constitutional ability to enter into international agreements rests at the federal congressional, not the state, level it is uncertain whether IEMAC could be ruled valid if ever tested because it was only approved by the US Senate.

SECTION 4 – REGIONAL BORDER HEALTH INITIATIVES

General

New and emerging diseases, including SARS and Avian Influenza, have underscored the need to ensure that geopolitical and jurisdictional boundaries do not impede infectious disease control and surveillance efforts. Diseases do not respect borders, making effective global collaboration critical in an age of escalating world travel and trade.

Differences in healthcare systems, government structures, cultural nuances and public health priorities all impact the coordination of streamlined international crisis response. And, while many informal communication pathways exist at the local level, official mechanisms are needed for effective state to province partnership in both routine and emergency situations.

Without a single planning entity to address issues along the entire US-Canadian border, states and provinces are in various stages of organizing with neighbouring jurisdictions. State and provincial public health leaders have taken the initiative in planning meetings that provide an opportunity for colleagues on both sides of the border to gather face-to-face and begin to tackle some of their common challenges. These meetings have allowed state and provincial public health workers to identify and establish relationships with their counterparts in other jurisdictions, collaborate on tabletop and other public health emergency response exercises, share information and best practices, and prioritize areas in need of greater coordination.

Evolving Alliances

- **Pacific Northwest**

  While formalization of a Pacific North West Border Health Alliance is currently a "work-in-progress", Washington (WA) State and British Columbia (BC) have been leading a public health collaboration since 2004. The focus of the collaboration has been an annual cross border workshop to address emerging public health threats, including pandemic influenza preparedness and tracking infectious disease across borders. Participation regularly includes representatives from the States of Alaska, California, Idaho, Michigan, Montana, New York, North Dakota, Oregon and Washington, the province of Alberta, British Columbia, Ontario and the Yukon Territory as well as several First and Tribal Nations and federal

Pacific North West Border Health Alliance

Alaska
British Columbia
Idaho
Oregon
Washington
Yukon

agencies. The meetings normally feature a tabletop exercise and breakout sessions targeted to key issues such as risk communication, surge capacity, public health law, and border quarantine. While these meetings initially focused on the public health aspects of cross-border preparedness, the addition of representatives from law enforcement, municipalities, the media, the acute and outpatient care systems, medical examiners, and border services agencies have provided a much broader perspective. In 2006 British Columbia and Washington signed a memorandum of understanding with respect to collaboration on the use of available public health and health services resources during emergencies. The most recent addition to the BC-WA collaboration is an Emergency Medical Services Working Group which has already produced many excellent recommendations on issues and concerns found in the Pacific Northwest Emergency Management Arrangement (PNEMA) and its functional application. In this regard, the focus of their effort has been the issue of medical staff with equipment and supplies and patients crossing the border between Washington State and British Columbia.

The Pacific North West Border Health Alliance is intended to instutionalize the current informal working groups to ensure sustainability of the collaborations. It is intended that the new alliance will replicated the Pacific North West Economic Region (PNWER) with the addition of Alberta and Montana to the original partners Alaska, British Columbia, Idaho, Oregon Washington and the Yukon

- **Mid-America**

The Mid-America Alliance is a coalition of ten state health departments in federal regions VII (Iowa, Kansas, Missouri, Nebraska) and VIII (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming) working together to develop a system of regional mutual aid among states to respond to public health emergencies such as infectious disease outbreaks and natural disasters. The coalition has established work groups focusing on the legal framework for the entity, data and information exchange, and sharing of resources including staff, and equipment assets to provide surge capacity in large, but sparsely populated regions.

Mid-America Alliance

Colorado
Iowa,
Kansas,
Missouri,
Montana,
Nebraska,
North Dakota,
South Dakota,
Utah
Wyoming

As a regional, multi-state collaborative program, the MAA plans and provides interstate mutual aid and support for multi-state response to public health crises not warranting a governor declared emergency. Furthermore, it provides a regional, all-hazard public health response system with mechanisms and processes for

escalating capability and establishes a state-based pilot program for testing public health readiness / performance indicators.

The MAA is governed by a Board of Directors composed of state health officers throughout the regions. Its organizational headquarters are located at the University of Nebraska Medical Center (UNMC) in Omaha with administrative support provided by the UNMC Center for Biosecurity.

- **Great Lakes**

The Great Lakes Border Health Initiative (GLBHI) was originally undertaken as the Michigan-Ontario Border Health Initiative in early 2004, following a border health assessment that identified a number of key challenges. These challenges included significant differences between the public health structures in the states and Ontario, communications, surge capacity, and the need for a cross-border mutual aid agreement. The GLBHI was subsequently expanded in the fall of 2004 to include Minnesota, New York and Wisconsin. In August 2006, the GLBHI welcomed the state of Ohio to the initiative. Funded by the Centers for Disease Control and Prevention's Early Warning Infectious Disease Surveillance (EWIDS) project, the GLBHI aims to formalize relationships between U.S. and Canadian public health and emergency preparedness agencies responsible for communicable disease tracking, control and response.

Great Lakes Border Health Initiative

Michigan
Ontario
Minnesota
New York and
Wisconsin
Ohio

The Michigan Department of Community Health has taken a leadership role with this effort. As the Border Health program enters its fourth year, it continues to build essential cross-border relationships and to perfect several draft documents aimed at formalizing data sharing and communication protocols.

Professionals in the fields of epidemiology, public health laboratories, emergency preparedness, public health law and infection control teleconference regularly via subcommittee, with representation from local, regional, state/provincial and federal public health levels. Tribal and First Nation stakeholders on both sides of the border have also been invited to the partnership.

Chief among the initiative's current projects:

- The implementation of an international test of the Michigan Health Alert Network

- The completion and test of the GLBHI Infectious Disease Emergency Communications Guideline
- Continued exploration into development of a possible Memorandum of Agreement (MOA) between Ontario and the involved states.
- Formalizing protocols for moving laboratory samples across the border
- Consideration of surge capacity near the border and identification of related issues.

- **Atlantic Canada and New England**

The creation of an Eastern Border Health Initiative (EBHI), comprised of the Maine Department of Health and Human Service, New Brunswick Department of Health and Wellness, New Hampshire Department of Health and Human Services, New York State Department of Health, Nova Scotia Department of Health Promotion and Protection, Quebec Ministry of Health and Social Services and the Vermont Department of Health was initiated in 2007. The EBHI was established to oversee the enhancement of collaborative early warning infectious disease surveillance and response between our jurisdictions, including at our international borders, and to develop a memorandum of understanding for cooperation between our jurisdictions. In addition to the state public health departments and provincial ministries of health, the offices of public or homeland security, border local health departments, border law enforcement authorities and border tribal nations are partners. Similar to the Great Lakes Border Health Initiative, the Northeast group is forming a steering committee and three work groups focused on communication infrastructure, epidemiology and investigation coordination, and public information and risk communication.

North East Region Public Health Partnership

Nova Scotia

New Brunswick

Maine

New Hampshire

New York

Quebec

Vermont

These regional collaborations have played an essential role in getting key people together to begin the process of developing an interoperable system for tracking and preventing the spread of outbreaks between the US and Canada. However, these regional meetings, as well as meetings between individual states and provinces, are not a substitute for a single entity which addresses cross-border public health preparedness issues common to the entire border. Under the current approach, there is duplication of effort as states and provinces lack an effective mechanism for sharing information about what has and has not worked in their various jurisdictions.

Additionally, the regional boundaries are not fixed. For example, the state of New York is involved in efforts with both Atlantic Canada-New England and the

Great Lakes states and provinces. Similarly, Montana, North Dakota and Alberta, which have been included in the northwest group, are engaging with the Mid-America Alliance with respect to public health laboratory and surveillance issues. While the states and provinces may reap many benefits from collaborating with multiple groups, significant time and effort must expended by staff that support and participate in these regional efforts.

Next Steps

It should be noted that not all provinces /territories or states have aligned themselves with one of the four cross border regional groups. These jurisdictions may not have the resources or interest in collaborating with other jurisdictions at this point in time. Ministries of health may find that only working with the one or more states that they directly border is the best use of their limited resources. It is also possible that they are not aware of the regional activities taking place.

There is also wide variance in the resources that each province/territory is able to bring to the table. Differences in staffing levels, financial support, and agency priorities among the provinces/territories result in an uneven playing field within the regions. Those jurisdictions with greater resources are forced to play a larger role in activities such as planning and hosting meetings in order for the regional collaborations to be successful.

SECTION 5 – OPPORTUNITIES AND CHALLENGES

OPPORTUNITIES

Surveillance Systems and Epidemiological Investigations

One of the primary cross-border preparedness activities between the states and provinces on the Canada-US border is the coordination of epidemiological and surveillance functions. The keys to controlling any infectious disease, whether it be pandemic flu or smallpox, are to identify it early, track its progress and rapidly put in place measures to contain it. This is also important in monitoring health effects in populations that neighbour a jurisdiction where an unintentional or terrorist event takes place. For example, a chemical explosion in one of the states may result in harmful substances being carried in a plume into one of the provinces. Similarly, a food borne outbreak will not be stopped by geographic boundaries.

Public health entities along the Canada-US border have traditionally collaborated in surveillance and epidemiology activities on an informal basis when outbreaks and other events have occurred. Over the years, public health staff have established relationships with some of their counterparts in neighbouring jurisdictions and have done whatever is considered necessary to enable an effective public health response to emergencies. While it is important that these informal channels remain, there is growing concern that more formal procedures need to be developed to ensure that the appropriate personnel are involved in the response, data standards and case definitions are consistent on both sides of the border, and privacy and other legal issues are considered.

Health departments in the north-western US states and their neighbouring provinces have exchanged 24/7 contact lists of staff involved in surveillance activities. They intend to test these contact lists as well as a mock exchange of surveillance data. Additionally, the states and provinces are working on public health agreements, to be discussed in more detail later, which will ease the exchange of surveillance information among them.

The initiatives in the Northeast and the Great Lakes are similarly working on public health agreements. One of the major efforts of the GLBHI is to improve surveillance compatibility and connectivity in the region. Participants in the Northeast Border Infectious Disease Surveillance Initiative are working to develop uniform case definitions, data collection tools and joint investigation protocols; implement an interagency incident command system; clarify legal issues related to privacy; and integrate electronically the data systems used by the various jurisdictions.

The federal provision of EWIDS funding has been an important financial resource for the states as they have begun to formalize their cross-border surveillance

activities. While state health departments are using EWIDS funds to support a wide variety of activities, the amount of funding available is not commensurate with the costs associated with building and maintaining a coordinated approach to cross-border public health surveillance. Additionally, because funding is based on the number of legal border crossings in each state, there is wide variation in the funding amounts to individual states. For instance, a state such as Michigan which has a high volume of legal border crossings in urban areas like Detroit receives significantly more funding than a state such as North Dakota, which likely has many undocumented border crossings in remote areas. Crossings which take place on tribal lands along the border are generally not documented[4].

Another limitation of EWIDS funding is its restriction to infectious disease surveillance. There is a great deal of concern among the states that this focus on infectious disease is hampering efforts to partner with other agencies that want to take an all-hazards approach to preparedness. Funding restrictions do not allow for all-hazards planning, preventing public health entities and their partners from considering infectious disease surveillance in the context of the overall effort to improve cross-border preparedness.

As the states continue these activities, they seek guidance from the CDC about electronic reporting and the need to ensure that standards are the same along the entire border. CDC guidelines could result in an interoperable surveillance system that would aid states and provinces in quickly responding to events and reducing their potential impact on the public.

The states also request greater flexibility regarding how EWIDS funds are spent. Variation exists in what is considered to be an acceptable activity under EWIDS. Providing greater latitude in justifications for proposed cross-border activities would be beneficial to the state health departments.

Laboratory Samples and Data

Public health laboratories play a critical role in disease detection and control. Within the US, much work has been done to improve laboratory capacity. The Laboratory Response Network (LRN) was established to expand surge capacity throughout the country. Laboratories within the network are designated to handle different types of biological and chemical testing, resulting in quicker responses throughout the network.

State health departments would like to see these capacities expanded to include Canadian laboratories beyond the two that are currently LRN-accredited. The health departments in Washington, Montana and other states are working to

[4] Final Report From The Indigenous Peoples' Border Summit Of The Americas II, San Xavier, Tohono O'odham Nation, November ,2007,

have additional Canadian laboratories added to the LRN to ease the sharing of information across the network. It is in the interests of both state and provincial health departments to share in the effort to quickly identify pathogens that could easily cross borders.

Expanding the network to more Canadian laboratories would improve capacity overall. Following the anthrax attack in the fall of 2001, laboratories in every state in the US received white powder that needed to be tested. A similar event in the future would stress the ability of public health laboratories to rapidly test and detect potentially harmful substances. The Great Lakes Border Health Initiative plans to conduct a survey of laboratory capacity in the region, collecting information about laboratory personnel and facility locations, reagent caches, and types of testing performed. Knowing what types of resources are available ahead of time will speed up efforts to deal with surge issues following an event.

The transport of laboratory specimens and personnel across the Canada-US border is a challenge. Various national and international regulations dictate which substances can be moved across borders and how. The Select Agent Rule in the US requires facilities to meet certain registration requirements in order to have high-threat biological agents and toxins in their possession. Under the Select Agent Rule, extensive paperwork is required regarding issues such as who can handle the sample, where it is stored and tracking the chain of custody.

There is considerable variation in the credentialing of laboratory personnel. In Canada, individual laboratory workers are licensed while in New York it is the laboratory directors who are licensed by the State Department of Health and Michigan it is the laboratories, rather than workers, that are licensed. Given these differences in credentialing, it is unclear whether personnel could perform laboratory testing in neighbouring jurisdictions without first addressing legal concerns.

State and provincial health departments are also working on issues related to laboratory communications. The Great Lakes Border Health Initiative is working on protocols for exchanging data and sharing laboratory results. The Montana Department of Public Health and Human Services added several Canadian laboratories to an email list that is distributed weekly to hospital labs in Montana. Montana and the Michigan Department of Community Health are working independently to identify differences in laboratory methods, measurement systems and test result interpretations. Differences between states and provinces in health privacy laws and regulations further complicate the exchange of information.

Many questions still exist for state health departments about what laboratory data can be shared across the Canadian border, who it can be shared with, and how it can be used. Issues such as the involvement of law enforcement in cases where the laboratory sample may be related to a terrorist act also need to be worked

out. The federal government may be able to provide guidance on some of these issues as well as working with the states and the Canadian provincial and national governments in areas such as expanding the LRN and possibly making it easier for laboratories to share samples during a crisis.

Communications

Fast, efficient and accurate communication is necessary to planning a successful response to emergencies. The first step to developing an effective communications strategy is to be able to identify counterparts. The states and provinces in the Northeast Border Infectious Disease Surveillance initiative have created a resource directory with 24/7 contact information for key health department staff. They have also shared organizational charts to aid in the identification of counterparts. Similarly, Ontario and the states involved with the GLBHI have exchanged contact lists.

State health departments have also developed methods to identify the most appropriate contact person and to determine when information should be shared. The Great Lakes and Northeast Initiatives have both created communication protocols for use by the state and provincial health departments in their regions. Other activities of the GLBHI include development of a decision tree and a table comparing reportable diseases in various jurisdictions. They are also working on templates for Health Alert Network (HAN) distribution within hospitals. Putting all of these practices into place will save valuable time as state and provincial health departments share needed information in the wake of an emergency.

Ongoing, consistent communications are also necessary. The Washington State Department of Health holds monthly conference calls and plans to add British Columbia to its WA-SECURES[5] service. Other states conduct similar activities to maintain ties with their counterparts in neighbouring jurisdictions. Regular communications during non-crisis times will lead to better coordination in the event of an emergency.

Communications are important not only among state, province and tribal nation health departments, but also between public health departments and the public. No public health message will be successful if the public is unable to hear it, cannot understand it, or does not follow it. Knowing ahead of time why borders may need to be shut down or why quarantine is sometimes necessary will result in greater acceptance if those measures are put into place. Ongoing risk communication will prepare the public for emergencies and increase the likelihood that they will safely and appropriately respond to public health messages during an emergency situation.

[5] Secure Electronic Communication, Urgent Response, and Exchange System

Risk communication activities are being targeted to first responders, the healthcare community and the media as well. First responders need to be aware of the health effects of various events. Consistency of information provided to the public and healthcare workers will improve the medical response to an emergency. The media play a critical role in linking health departments to the public. Assuring that the media receive accurate information will improve the chances that the public will hear necessary information. The reach of television, radio and print media overlaps various jurisdictional boundaries and audiences. Health departments are working to coordinate their messages so the same information is provided anywhere in the region, regardless of which source the public uses.

Consistency and accuracy of information is needed before and after an event takes place. By continuing to improve interagency communication and to share important risk communication, provincial/territorial health departments are strengthening their day-to-day relationships with their cross border partners, thus raising the level of trust in and acceptability of preparedness messages and the public health officials who deliver them.

Education and Training

Provinces are also working to improve education and training, both for health department staff and members of the public. Included in these education activities are the ongoing risk communication efforts. Focused on the all-hazards approach, health departments are working to prepare the public for a variety of public health emergencies that may have a cross-border component.

Staff training has focused on increasing the level of knowledge about the similarities and differences in the public health preparedness activities in Canada and the US and in identifying areas where a common knowledge can be developed. By learning more about the procedures and terminology in each others jurisdiction, state and provincial health department staff will be more likely to effectively communicate and work together in an actual crisis.

Through educational and training the opportunity exists to address a variety of other interoperability activities, such as the use of common case definitions in epidemiological investigations or sharing a common nomenclature for lab samples. Training opportunities also present in other areas, such as exercising a common system for emergency response. Using the same type of incident command system on both sides of the border, for instance, would result in a more coordinated, efficient response.

A critical component of staff education and training has been the activities enabled by the regional collaborations. Meetings have already been held that provided opportunities for participants to meet each other, share information about how they do things in their own health departments, and identify projects

on which they can collaborate. For example, the tabletop exercises conducted at the Northwest and Great Lakes meetings have allowed participants from many jurisdictions to discover how they might jointly tackle serious cross-border public health emergencies.

Finding ways to make these opportunities available to more staff will only improve the ability of health departments to handle cross-border events. Given the limited resources of many health departments, it is often difficult for staff to devote adequate time to training and education opportunities or for the health departments to send multiple staff to conferences and other educational events. Discovering better methods to share information and best practices among all the states along the Canadian border would be of great benefit to the staff engaged in cross-border preparedness activities.

Standardization/Interoperability

In a disaster, health services must be fully integrated and interoperable at all government levels. To the extent possible, planners must address enhanced portability and sustainability between the emergency response and acute care systems through identification, availability and use of standardized equipment and protocols for communications, personal protection and agent detection, as well as for medical and operational emergency preparedness throughout the duration of an emergency event.

It should be noted that Canada currently subscribes to patient management standards through ratifying and implementing formal agreements established by international forums, such as the North Atlantic Treaty Organisation (NATO). The Emergency War Surgery Handbook, a widely used disaster medicine reference, is an example of an international effort to achieve consistency in casualty care..

CHALLENGES

Legal and Administrative

Liability Protection: In order to receive personal and professional liability protections of a particular agreement or law, deployed personnel will normally be required to register as emergency workers by the receiving local emergency management agency. The challenge here being having health emergencies recognized as emergencies without being specifically declared as such.

Workforce Identification and Training: In many jurisdictions the provincial/ territorial/state health ministry/department is responsible to maintain an inventory of physician and nurse assets deployable under mutual assistance agreements. Where data bases are maintained the listings are generally (at this point in time)

limited to physicians, nurses, and mental health professionals. In this regard, assets identified under a resource typing scheme should meet all the agreed training and credentialing requirements for that type of asset.

Most jurisdictions party to a mutual assistance agreement will not form pre-designated response teams. Rather, teams may be formed ad hoc at the time a need for a specific team type is identified or thought to be imminent. As such, pre-event collective team training will not be possible.

Personal Protective Equipment: The receiving jurisdiction and institutions or agencies will ensure that personnel deployed from the staging area will have adequate personal protective equipment prior to commencing their duties. If vaccination is required, that will be provided by the receiving jurisdiction or institution and must be administered prior to commencing duties.

Licensure: During a declared emergency, whenever a person of the sending jurisdiction holds an active and unencumbered license, certification or other permit to practice as a physician or nurse, and such assistance is requested by the receiving jurisdiction; such person is deemed to be licensed, certified or permitted to practice by the jurisdiction requesting assistance, to the extent allowed by law.

Credentialing: The requesting jurisdiction is responsible for providing a descriptive request, which must clearly define medical scope of practice, any particular skills needed, such as licensed and practicing orthopaedic surgeon specializing in knee reconstruction, and any licensure or credentialing documentation needed by the medical volunteer, in order to fulfill the request. It should be noted that the ultimate responsibility for credential verification resides with the requesting facility/end user institution.

Reimbursement:

The authority of jurisdictions to commit resources must be both clearly established and understood prior to an event as very often the actual signatories to an agreement often do not directly control the assets committed in mutual assistance agreements. For example, in British Columbia with the exception of private health care practitioners virtually all health services resources are owned by regional health authorities. In this regard, agreements and arrangements should recognize the potential requirement to reimburse incremental and extraordinary expenses incurred by the resource providers for back-fill and staff overtime.

Border Crossing Documentation:

As part of the Western Hemisphere Travel Initiative (WHTI), beginning January 23, 2007, all persons, including U.S. citizens, traveling by air between the United States and Canada will be required to present a valid passport, Air NEXUS card, or U.S. Coast Guard Merchant Mariner Document.

As early as January 1, 2008, all persons including U.S. citizens, traveling between the U.S. and Canada by land or sea (including ferries), may be required to present a valid passport or other documents as determined by the Department of Homeland Security. While recent legislative changes permit a later deadline, the Departments of State and Homeland Security are working to established a more streamlined border crossing protocol.

The Department of Homeland Security has granted the State of Washington permission to develop, as a pilot project, an enhanced drivers license (or personal identification card) that will allow the holder to cross the border without the other documents specified above. The document will be based on the standard Washington State driver license or identification card, but would be enhanced to meet the requirements of the WHTI. The enhanced driver license would:

- be a voluntary program;
- be slightly more expensive than a standard license;
- require proof of citizenship, identity, and residence; and
- be more secure than a standard license, and similar in security features to a U.S. passport.

SECTION 6 – PUBLIC HEALTH AGREEMENTS AND ARRANGEMENTS

General

No single state or provincial health department has all of the resources that would be needed to deal with a large-scale public health emergency. Particularly when events are wide in scope or require the dedication of resources over an extended period of time, health departments must rely on their counterparts in other jurisdictions to fill in gaps, provide supplies, and relieve overstressed public health staff.

Naylor and others have clearly articulated the need for multi-jurisdictional collaboration in public health[6]. It has become evident, particularly during a complex emergency/ disaster such as Hurricane Katrina, that multilateral approaches are often the most efficient means to address gaps in health system capacity[7]. In this regard, pre-negotiated arrangements between entities will greatly expedite the provision of assistance.

It should be noted that intra-health authority/region mutual assistance arrangements are as, and possibly more, essential as inter-jurisdictional arrangements.

While the US EMAC allows member states to share personnel and equipment during Governor-declared emergencies, states have recognized that health emergencies are not effectively addressed. The Mid-America Alliance was established to provide mutual assistance in public health emergencies that have not been declared by a Governor. In its early stages of development, the Alliance is currently focused on identifying available resources in the member states, developing a strategy for sharing data and information, planning for epidemiological and laboratory surge capacity, and drafting legislation to ease the exchange of public health personnel. State health departments would like to be able to enter into arrangements similar to EMAC and the Mid-America Alliance with their Canadian neighbours.

Washington State has been leading an effort to add an annex to PNEMA which would specifically address issues related to public health that occur in emergencies. In particular, the dissemination of health data and licensing and liability of healthcare personnel are among the topics that would be addressed in a public health annex.

[6] The National Advisory Committee on SARS and Public Health. Learning from SARS: Renewal of Public Health in Canada. Ottawa: Health Canada; 2003
[7] Partners in Public Health Report – pages 45-46

Other states are also looking at existing emergency management agreements to determine whether they can be applied to public health components of emergencies. For example, two of New York's border counties have a cross-border contingency plan with an Ontario municipality. Agreements such as the Great Lakes Forest Fire Compact may also serve as models for cross-border public health preparedness agreements.

In establishing these agreements is important to identify what types of resources are available in a region and to avoid legal disagreements following an incident. Resources typing, joint training exercises and command structures can all be pre-identified under these agreements. Signatories of the agreements can also predetermine healthcare licensure requirements, a dispute resolution process, recordkeeping requirements and reimbursement for services and supplies.

It is unclear how much authority states have in these types of agreements, however. State health departments are conducting their cross-border preparedness activities under the direction of the federal government and may have some latitude as their goal is to protect the public. It would be helpful for the states to receive additional guidance from the federal government about limitations to their activities.

International Agreements

Canada-United States Mutual Aid Memorandum of Understanding. This MOU is intended to establish a mutual aid agreement between Canada and the US to provide a framework for orderly deployment of health emergency assistance between the two countries. It would include a plan to build and strengthen mechanisms, protocols and agreements for communicating and coordinating health emergency response, including protocols for mutual assistance and cooperation in the event of natural and technological/industrial disasters or malicious acts involving chemical, biological, radiological, nuclear devices and hazards.

With a view to creating a public health emergency management system that is interoperable both along and across Canada-US borders it will be necessary to assess existing mechanisms and protocols and develop a plan to address gaps. Specific issues for consideration include:

- stockpiling of vaccines and other public health countermeasures;
- implementing a control system for tracking and monitoring the movement of dangerous human pathogens within North America.
- establishing information-sharing protocols, for surveillance activities and emergencies through interoperable systems, to rapidly detect and monitor infectious diseases

- developing a mutually prioritized list of critical cross border health facilities and systems and agree to a prioritization protocol; and
- enabling critical infrastructure operators in the health sector to share best practices, lessons learned, methodology frameworks and other critical data.

National

Federal/Provincial/Territorial Memorandum of Understanding (MOU) on the Provision of Mutual Aid in Relation to Health Resources During an Emergency Affecting the Health of the Public

In March of 2005, the F/P/T Ministers of Health and the Conference of F/P/T Deputy Ministers of Health (CDMH) tasked the Pan-Canadian Public Health Network with developing an F/P/T agreement for mutual aid in the event of an emergency. A MOU was subsequently developed to outline common principles for providing inter-jurisdictional assistance to one another during a public health emergency and builds on existing emergency management agreements in the northeast and northwest.

The purpose of the MOU is to provide for the possibility of mutual assistance among jurisdictions entering into this agreement in managing any public health emergency or disaster when the affected jurisdiction or jurisdictions ask for assistance. The intent is not to absolve a jurisdiction of its responsibility to adequately prepare for emergencies, but rather to provide access to additional resources as an extra tool upon which a jurisdiction can rely.

The MOU also provides for the process of planning mechanisms among the agencies responsible and for mutual cooperation, including, if need be, the temporary licensing of health care professionals. In addition, the MOU also addresses the issues of liability and indemnification, reimbursement, workers' compensation, dispute resolution, supplementary agreements, accountability and reporting.

It is recognized that most governments do not control the majority of human and/or physical resources. Therefore, the provincial/territorial role may be limited to considering requests for assistance. Furthermore, the MOU recognizes that in some situations, the aid that will be provided will be advisory only and not require the physical movement of people or goods.

In recognition of the Pan-Canadian political environment, the content of the MOU has been limited to the essential principles that will enable the exchange of assistance during a public health emergency. These include provisions to:

- allow health personnel from another jurisdiction to be licensed on a temporary basis while assigned to a different jurisdiction.
- indemnify health personnel assigned to the jurisdiction against liability on account of an act or omission done in good faith (unless the act or omission is the result of wilful misconduct, gross negligence or recklessness).
- provide workers compensation and death benefits that apply to health personnel who may be injured or die while on assignment in your jurisdiction.

Federal/Provincial/Territorial Memorandum of Understanding (MOU) on Information Sharing During a Public Health Emergency/Event

The F/P/T information sharing MOU was, as the title would suggest, developed to facilitate jurisdictions sharing timely, accurate and sufficiently detailed information regarding a potential or actual public health emergency, including where necessary case definitions, case information, laboratory results, source and type of the risk, number of cases and deaths, conditions affecting the spread of the disease and the health measures employed. While respecting applicable privacy laws, the MOU requires an impacted jurisdiction to report, as necessary, the difficulties faced and support needed in responding to the emergency.

In developing the MOU the authors were cognisant of the fact that the collection, use and disclosure of personal information, including personal health information, is to be carried out in the most limited manner necessary as authorized by law or an individual's consent, on a need-to-know basis, with the highest degree of anonymity possible in the circumstances and using the least invasive means. Once a public health emergency has ended, jurisdictions will return to the routine information sharing processes that were in place prior to the emergency.

Inter-Jurisdictional

Memorandum of Understanding on Public Health Emergencies Between the Province of British Columbia and the State of Washington

The Washington State Department of Health (DOH) and the British Columbia Ministry of Health (MOH) since 2004 have jointly sponsored an annual cross border public health workshop on emerging public health issues, including pandemic influenza.

In June 2006 a MOU titled *Memorandum Of Understanding With Respect To A Collaborative Approach To Use Of Available Public Health And Health Service Resources To Prepare For, Respond To And Recover From Public Health Emergencies* was been signed by BC and Washington health officials in

response to the recognized need to formalize existing informal communication/ collaboration through an agreements between public health partners.

In developing the MOU, the partners agreed to undertake a collaborative approach on the use of available health service resources to prepare for, respond to and recover from public health emergencies. They also agreed that other existing regional agreements that support meeting such demands during emergencies need to be clarified to ensure a common understanding, and to explore possible new areas of joint collaboration.

Great Lakes Border Health Initiative (GLBHI) Public Health Data Sharing Agreement

The purpose of this agreement is to facilitate sharing of public health related data, both individually identified and population-related, between GLBHI jurisdictions for the purpose of preventing, detecting or responding to a public health emergency/event, thus assuring prompt and effective identification of infectious disease and other agents that could affect public health in the Great Lakes Region, and to prevent further spread of disease.

SECTION 7 – FIRST AND TRIBAL NATIONS CONSIDERATIONS

General

The borders between provinces/territories and states are not the only ones that Canada-US border jurisdictions are concerned about. They also face the challenge of incorporating the needs and goals of the federally-recognized First and Tribal Nations into their preparedness plans. Provinces and states have begun working with First and Tribal Nation governments with varying degrees of success, with several jurisdictions providing grants to the First and Tribal Nations within their borders to conduct preparedness activities. They are also working to build trust between themselves and the First and Tribal Nations and to respect cultural traditions when planning preparedness activities that impact indigenous populations.

While representatives from provincial/state health authorities have been meeting with representatives from the First Nations and tribes, members of the respective councils who are empowered to make decisions are not always present and aware of these activities. Similarly, the authority of provinces and states to negotiate with the First and Tribal Nations varies. Federal guidance, for example, may be needed to determine responsibility for isolation and quarantine on First and Tribal Nation's lands.

The challenges associated with working with First and Tribal Nations extend beyond those related to cross-border public health preparedness due to issues related to sovereignty, cultural differences and historical distrust. Provincial/state health departments will continue to work with their tribal partners to develop stronger relationships and to ensure that those living on tribal lands are adequately protected during public health emergencies. Provincial and state health authorities appear to be interested in pursuing a collaborative initiative designed specifically to address First and Tribal Nations issues and to coordinate with the First and Tribal Nations in the development of a collaborative border health effort. In this regard, all of the regional health collaborations have invited participation from their respective Tribal and First Nations.

Canadian Perspective

In Canada, responsibility for aboriginal health is shared between the federal and Provincial/territorial governments.

Health Canada, through the First Nations and Inuit Health Branch (FNIHB), provides a range of First Nations and Inuit health programs and services including primary care services in approximately 200 remote communities, and home and community care in over 600 communities. Health Canada employs approximately 665 nurses to deliver health services to communities, and maintains nursing stations, community health centres and other health service

facilities. In addition, health services are provided by nursing staff and other health care workers directly employed by communities through health service transfer agreements and contribution agreements.

While FNHIB is responsible for primary health care services care on reserves, provincial and territorial health services provide service to off-reserve First Nations and Inuit populations. Acute and tertiary care services are provided by provincial/territorial health services.

Health Canada's role in First Nations and Inuit health goes back to 1945, when Indian health services were transferred from Indian Affairs. In 1962, Health Canada provided direct health services to First Nations people on reserve and Inuit in the north. By the mid 1980s, work began to have First Nations and Inuit communities control more health services. In recent years, First Nations and Inuit health has improved in areas such as living longer and preventing infant deaths. Despite improvements, gaps remain in the overall health status of First Nations and Inuit compared to other Canadians. For example, First Nations people and Inuit have higher rates of injury, suicide and diabetes then non aboriginal populations.

Through its regional offices, FNHIB provides programs and services focusing on children and youth, mental health and addictions, chronic diseases, environmental health, and communicable and non-communicable disease prevention. These services supplement and support the services that provincial, territorial and regional health authorities provide. For example, the First Nations and Inuit Home and Community Care program supports the delivery of quality home and community-based services to support those with chronic diseases, persons with disabilities and the elderly in over 640 communities. Through the Non-Insured Health Benefits Program, drugs, dental care, vision care, medical supplies and equipment, short-term crisis intervention, mental health services, and medical transportation will continue to be available to all 780,000 registered Indians and recognized Inuit in Canada.

United States Perspective

In many states, Tribal Nations are treated like local jurisdictions. For example, In Montana, all Tribal Nations have contracts for preparedness work in the same manner as counties in the state. Similarly, 26 of the 29 tribes in Washington State have received grants of up to $100,000 for preparedness activities. By funding the tribal nations in this way, the states allow greater autonomy to the tribes and flexibility in how the funds are spent. The state health departments are able to provide the tribes with needed resources while respecting their sovereignty rights.

The New York State Department of Health completed onsite needs assessments to identify specific needs and priorities for its tribal nations. The state has made

progress in integrating the tribes with local health departments and increasing the trust level by delivering on promises to the tribal nations. Montana organized two cross-border terrorism preparedness conferences in May and August of 2004 which included participation from the tribes. During both conferences, the culture of Native Americans was respected and celebrated. From Native American theme dinners to a Native American Roundtable, tribal nation traditions were incorporated throughout the conferences.

As in many communities throughout the US, one of the obstacles to engaging the tribal nations in public health preparedness activities is demonstrating to the population that such activities are relevant to their specific circumstances. One example of a tribe that has embraced the need to be prepared is the Blackfeet Nation along the Montana-Alberta border. The Blackfeet are planning an exercise for September 2005 focused on the roles of the tribal nations and the IHS in an emergency. Lessons learned from this exercise will help the Montana Department of Public Health and Human Services better understand how to meet the needs of the tribes within the state and may serve as a model for other states and tribal nations.

As states continue to collaborate with their tribal partners, they are working to include the appropriate tribal nation representatives in planning. In many cases, members of the tribal council are the only ones with the authority to make decisions and enter into agreements on behalf of their tribe. Having full involvement by tribal council members in all phases of cross-border preparedness planning relevant to tribal nations will help increase the likelihood of successful collaborations with the tribes.

State health departments will not be able to overcome all of the challenges related to working with tribal nations. Because the tribal nations are sovereign entities, states lack authority needed to negotiate agreements and to order the tribes to undertake important public health preparedness activities. It is unclear, for example, whether state health departments would be able to order isolation or quarantine on tribal lands.

States need support and guidance from the federal government in dealing with funding and sovereignty issues. In many cases, the federal government is the most appropriate and the only authoritative body that can move these issues forward. Additionally, many of the difficulties that states face in collaborating with tribal nations on cross-border public health preparedness are quite different from the challenges in working with the provinces or other states. The state health departments will continue to work with their tribal partners and a meeting focused solely on improving state-tribal collaboration on public health preparedness issues may be beneficial to both the states and the tribal nations.

SECTION 7 – NEXT STEPS

General

Over the past few years health services planners at the provincial, territorial and state level have conducted numerous roundtables and workshops with a view to developing an achievable plan of action for the way ahead. In this regard four strategic focuses have been identifies: 1) explore the creation of a US-Canada border public health preparedness planning entity; 2) support comprehensive federal coordination of federal programs related to cross-border public health preparedness; 3) advocate for consistent federal support of all-hazards cross-border preparedness planning; and 4) coordination with tribal nations on public health preparedness activities.

Canada-United States Border Public Health Preparedness Planning Entity

A key priority of the Canadian jurisdictions along the Canada-US border is the development of a mechanism to address the public health preparedness needs of the entire border. State health departments and provincial ministries of health are engaged in various pockets of work related to EWIDS, laboratory surge capacity, risk communication and others. They have naturally formed regional collaborations with their neighbouring jurisdictions to begin finding common ground in how they manage their preparedness activities and how they might best assist each other. However, not all jurisdictions are participating in these collaborations and the staff who do participate must devote considerable time and effort to remain engaged in these activities as well as work going on at the local/regional level between their own provinces and individual states.

Unlike the southern border, which has a US-Mexico Border Health Commission, there is no single entity that can assist the provinces and states along the Canada-US border in their efforts to coordinate various activities. The establishment of a Canada-US Border Health Commission or similar organization would allow the provinces and states to take a global approach to the entire border.

The creation of a Canada-US Border Health Commission could facilitate a single cross-border public health agreement rather than the multiple agreements that different regions have developed or are considering. The existence a formal structure could also aid health departments in working with other emergency response partners such as police and fire departments and emergency management agencies.

A Canada-US Border Health Commission would allow the border provinces/territory/states to more effectively collaborate to address common challenges, share resources, and identify strengths and weaknesses. As such, it would provide a forum for sharing best practices and encourage the development

of a unified effort to ensure public health preparedness across the entire border region. Lastly, It could also serve an advocacy role on behalf of the provinces/territory/states as other areas of collaboration are identified, such as health living initiatives.

Federal Programs Related to Cross-Border Public Health Preparedness

Research for this paper indicates that provincial/territorial health authorities would like to see comprehensive federal coordination of the various federal programs related to cross-border public health preparedness. It appears that a number of federal agencies, some with very distinct and dissimilar interests, including Health Canada, the Public Health agency of Canada, Indian and Northern Affairs Canada, the Revenue Canada/Canadian Border Services Agency, have jurisdiction over various activities that impact cross-border preparedness.

Additionally, each province/territory is challenged to work with the US federal government as well as one or more bordering states. Greater coordination at the federal level would achieve consistency across the border region and eliminate time and resource-wasting duplication of effort. Federal coordination is also needed to address international laws and standards that states may not have the authority to engage in.

All-Hazard Cross Border Preparedness Planning

Provincial/territorial health ministries need consistent federal support for all-hazards cross border preparedness planning. South of the border, states receive additional funding for carrying out EWIDS activities; however, the amount of this funding is not commensurate with the costs of successfully planning and implementing the program's objectives. Though the activities are considered optional by the CDC, state health departments recognize their value and believe they must carry them out in order to assure they are adequately prepared.

Current funding from all sources is insufficient for the scope of identified cross-border preparedness issues. As provinces/territories/states work together it is obvious they come to the table with very different resources.

While Canadian provinces have benefit from the EWIDS funds received by their bordering states, restricting funding to primarily surveillance activities is contrary to the goal of all-hazards preparedness. Recognition of the costs of ensuring cross-border preparedness as well as providing greater flexibility in the justifications for spending priorities is needed from both the Canadian and US federal governments.

SECTION 8 – CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Although existing emergency management assistance agreements facilitated the movement of an unprecedented amount of mutual aid to Katrina-affected disaster areas, inadequacies in the response demonstrated a need for improvement. This is particularly evident, particularly with regard to the resolution of human resources issues, such as licensure portability, liability protection/indemnification, compensation and benefits.

Because the provisions of most mutual assistance agreements are triggered only for declared emergencies, the sharing of resources during smaller scale, undeclared emergencies must be must be effectuated by separate agreements. The same holds true with regard to the sharing of epidemiological or laboratory data designed to detect threatened infectious disease outbreaks. It may even hold true, in some circumstances, that routine public health functions would be more effectively performed by executing collaboration agreements to share relevant information, supplies, or equipment.

Recommendations

It is recommended that:

- The Public Health Agency of Canada provide leadership and assistance with respect to:
    - establishing a Canada-US border health forum with a view to establishing appropriate protocols and processes for the effective cross border management of public health emergencies; and
    - convening a cross border meeting to address First and Tribal Nations issues and to coordinate with the First and Tribal Nations in the development of a collaborative border health effort.

- Provincial/Territorial governments provide leadership and financial assistance to:
    - enable border health entities to collaborate in the development of local mutual assistance initiatives to ensure a timely and seamless response to public health emergencies impacting their respective jurisdictions.

REFERENCES

Agreement Between the Government of The United States of America and the Government of Canada on Cooperation and Comprehensive Civil Emergency Planning and Management, Ottawa and Washington, 1986

British Columbia-Alberta Alberta Memorandum of Understanding on Public Health Emergencies, Edmonton and Victoria, 2004

A Memorandum of Understanding Between the Province of British Columbia and the State of Washington, Seattle and Victoria, 2006

Pacific Northwest Emergency Management Agreement, 1998

International Emergency Management Assistance Memorandum of Understanding, 2007

Development of Public Health Mutual Aid Agreements – a Menu of Suggested Provisions, US Centers for Disease Control and Prevention Public Health Law Program, Atlanta, 2007

Emergency Management Assistance Compact Enhancing EMAC's Collaborative and Administrative Capacity Should Improve National Disaster Response, US Government Accounting Office GAO-07-854, June 2007

Annex A

Canada-United States Cross Border
Public Safety and Emergency Management Agreements and Arrangements

Initiative	Description	Lead Jurisdiction	Current Status
Agreement Between the Government of The United States of America and the Government of Canada on Cooperation and Comprehensive Civil Emergency Planning and Management	Established Consultative Group on Comprehensive Civil Emergency and Management	DFAIT (CA)	• Signed April 1986 • Renewed December 1998
Western-Regional Emergency Management Advisory Committee (W-REMAC)	Established as one of four REMACs (Eastern, Central, Prairie and Western) to promote emergency management coordination and preparedness at regional levels and to complement the work of the CA/US Consultative Group.	FEMA Reg X (US)	• W-REMAC oversees the management and implementation of the PNEMA • Meets at least annually
Pacific Northwest Emergency Management Arrangement (PNEMA)	An arrangement under the aegis of the W-REMAC to address regionally-based emergency preparedness, response and recovery measures for the benefit all jurisdictions within the Pacific Northwest, and to serve respective national interests in cooperative and coordinated emergency preparedness	WA EMD (US)	Signed April 1996

Initiative	Description	Lead Jurisdiction	Current Status
International Emergency Management Assistance Memorandum Of Understanding (PNEMA Annex B)	The MOU provides for the process of planning mechanisms among the agencies responsible and for mutual cooperation, including, if need be, emergency-related exercises, testing, or other training activities using equipment and personnel simulating performance of any aspect of the giving and receiving of aid by party jurisdictions or subdivisions of party jurisdictions during emergencies, with such actions occurring outside actual declared emergency periods. Mutual assistance in this compact may include the use of emergency forces[8] by mutual agreement among party jurisdictions.	WA EMD (US)	Jurisdictions developing operational plans using authorities of the PNEMA
Inter-provincial/ territorial Emergency Management Assistance Compact (Preliminary Draft)	The compact when/if approved would provide for the possibility of mutual assistance among the governments in managing any emergency or disaster when the affected government or governments ask for assistance, whether arising from natural disaster, technological hazard, man-made	PSEPC	Unknown

[8] Emergency forces include but are not limited to: police/security forces; and fire-rescue (Hazmat/USAR): emergency medical and emergency management services

Initiative	Description	Lead Jurisdiction	Current Status
	disaster or civil emergency aspects of resources shortages.		
Canada-United States-Mexico Security and Prosperity Partnership	The Security and Prosperity Partnership (SPP) Initiative came out of the March 23, 2005 meeting in Waco, Texas, of Presidents Bush and Fox and Prime Minister Martin where they agreed on a broad, far-reaching agenda in the area of security, prosperity and quality of life. The SPP includes a range of sectors where it was agreed that collaborative action could enhance security and prosperity in our three countries.	US State Department	On-going
International Emergency Management Assistance Compact	The IEMAC was created to address the possibility of mutual assistance among the partners to the compact in managing any emergency or disaster when an affected jurisdiction or jurisdictions requests assistance, in dealing with the consequences of natural disaster, technological hazard, man-made disaster or civil emergency aspects of resources shortages. The current membership includes the States of Maine, New Hampshire, Vermont,		Provincial/state approved 2000 Ratified by US Senate October 2007 Implemented • Feb. 2004: "White Juan" snowplows sent from Maine and New Brunswick to Nova Scotia • Aug. 2004: Blankets sent from Quebec to Vermont

Initiative	Description	Lead Jurisdiction	Current Status
	Massachusetts, Rhode Island, and Connecticut and the Provinces of Québec, New Brunswick, Prince Edward Island, Nova Scotia and Newfoundland and Labrador.		during outdoor concert - 2000 blankets on scene within 12 hours

Annex B

Canada-United States Cross Border Public Health Agreements, Arrangements and Memorandum of Understanding

Public Health

Initiative	Description	Lead Jurisdiction	Current Status
Federal/Provincial/ Territorial Memorandum of Understanding (MOU) on the Provision of Mutual Aid in Relation to Health Resources During an Emergency Affecting the Health of the Public	MOU establishes a framework for Jurisdictions to provide and receive human and material health resources having regard to the unique and complex health care delivery structures and health professional regulatory environment in each jurisdiction. While it describes the general intentions of the jurisdictions it does not create or describe legally binding obligations and does not limit or derogate from the exercise of any statutory power or legislative authority of each jurisdiction.	PHAC/CEPR	Pending formal F/P/T sign-off
Federal/Provincial/Territorial Memorandum of Understanding (MOU) on Information Sharing During a Public Health Emergency/Event	MOU was developed facilitate sharing timely, accurate and sufficiently detailed information regarding a potential or actual public health emergency, including where necessary case definitions, case information, laboratory results, source and type of the risk, number of cases and deaths,	PHAC	Pending formal F/P/T sign-off

Initiative	Description	Lead Jurisdiction	Current Status
	conditions affecting the spread of the disease and the health measures employed.		
Mutual Aid Agreement for Health Emergency Preparedness and Response in First Nations (on reserve) and Inuit communities	The purpose of the agreement is to delineate responsibility for health emergency preparedness and response.	PHAC	Work in progress
Alberta - British Columbia Memorandum Of Understanding with Respect to a Collaborative Approach to Use of Available Health Service Resources to Prepare For, Respond To and Recover From Public Health Emergencies	MOU provides a framework for on-going collaborative work, including mutual assistance and interagency and interdisciplinary collaboration to prepare for, respond to and recover from public health emergencies.	BC MOH/EMB	• Signed May 2004 • Validation TTX being developed
Memorandum of Cooperation Between the Province of British Columbia and the State of Washington	MOU provides a framework for on-going collaborative work, including mutual assistance and interagency/interdisciplinary collaboration to prepare for, respond to and recover from public health emergencies.	MOH/EMB (BC)	• Signed June 2006 • Public health laboratory surge capacity MOU between labs in WA and BC[9]
Pacific North West Public Health Preparedness Collaboration/Western Border Health Initiative	To recognize the need to institutionalize the current informal Pacific Northwest public health partnership structure as a means to	BC MOH/EMB WA DOH	• Preliminary consultation underway • Proposed initial membership:

[9] A public health laboratory surge capacity MOU currently exists between labs in WA, ID, OR, and AK

Initiative	Description	Lead Jurisdiction	Current Status
	improve general collaboration on mutual health issues and to continue efforts leading towards seamless public health preparedness and response capabilities across the CA-US border.		States of Alaska, Washington, Oregon and Idaho and the Province of British Columbia, and the Yukon Territory with the possibility of expanding to include all PNWER[10] jurisdictions.
Pacific North West Cross Border Public Health Collaboration Memorandum of Understanding	Similar to the BC-AB and BC-WA MOU, provides a framework for on-going collaboration, including mutual assistance and interagency/interdisciplinary information exchange to prepare for, respond to and recover from public health emergencies.	MOH/EMB (BC)	Concept was been proposed to WA DOH colleagues in September 2007
Washington State Cross Border Ambulance Reciprocity Policy Statement	Statement of requirements and limitation for transporting patients across Washington State borders by ground or air ambulance.	DOH (WA)	Discussions currently underway between US DHS, WA DOH, CBSA and BCAS regarding WA-BC border crossings issues
Great Lakes Border Health Initiative Public Health Data Sharing Agreement	The purpose of this Agreement is to facilitate sharing of public health related data, both individually identified and population-related, between signatories for	DOH (MI)	Approved fall 2007

[10] Pacific North West Economic Region

Initiative	Description	Lead Jurisdiction	Current Status
	the purpose of preventing, detecting or responding to a public health event, thus assuring prompt and effective identification of infectious disease and other agents that could affect public health in the Great Lakes Region, and to prevent further spread of disease.		
Great Lakes Border Health Initiative Infectious Disease Emergency Communications Guideline	The purpose of the guidelines is to enhance early warning infectious disease surveillance along the international border by creating a tool to categorize emergency vs. non-emergency public health events and to pre-determine preferred routes of communications for such events involving the partners	MI DOH	Approved fall 2007 The guidelines were subsequently used when a case of drug resistant streptococcus pneumoniae was reported in Ontario. In response to the case, officials in Ontario notified all the GLBHI members using the steps outlined in the guidelines.